		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015651

Facility Name: Bethany Terrace Nursing Centre

Address: 8425 North Waukegan (Number) Morton Grove (City) 60053 (Zip Code)

County: Cook

Telephone Number: (847) 965-8100 **Fax #** ( )

IDPA ID Number: 36-2012788

Date of Initial License for Current Owners: 2/13/69

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Harold Reisler **Telephone Number:** (773) 989-1465

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/02 to 9/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Wolfgang Mayer
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	170	Intermediate (ICF)	170	62,050	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,529	1,794	6,252	10,575	8
9	SNF/PED					9
10	ICF	30,307	35,989	2,891	69,187	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,836	37,783	9,143	79,762	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/13/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 45 and days of care provided 4,695

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 10/1/02 Fiscal Year: 9/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	549,741	48,806	(51,618)	546,929		546,929	(67,682)	479,247			1
2	Food Purchase		566,357		566,357		566,357		566,357			2
3	Housekeeping	326,673	56,349	3,846	386,868		386,868		386,868			3
4	Laundry	57,656	63,884	194,568	316,108		316,108		316,108			4
5	Heat and Other Utilities			211,411	211,411		211,411		211,411			5
6	Maintenance	93,839	21,350	140,658	255,847		255,847		255,847			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,027,909	756,746	498,865	2,283,520		2,283,520	(67,682)	2,215,838			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,625,545	482,423	82,970	5,190,938		5,190,938		5,190,938			10
10a	Therapy	88,764	4,868	310,096	403,728		403,728		403,728			10a
11	Activities	153,613	2,962	27,203	183,778		183,778		183,778			11
12	Social Services	96,018	143	248	96,409		96,409		96,409			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,963,940	490,396	420,517	5,874,853		5,874,853		5,874,853			16
	C. General Administration											
17	Administrative	97,148		180,228	277,376		277,376	(230,359)	47,017			17
18	Directors Fees											18
19	Professional Services			46,768	46,768		46,768	(44,863)	1,905			19
20	Dues, Fees, Subscriptions & Promotions			36,150	36,150		36,150	(647)	35,503			20
21	Clerical & General Office Expenses	223,680	18,738	535,241	777,659		777,659	(22,317)	755,342			21
22	Employee Benefits & Payroll Taxes			753,005	753,005	10,277	763,282		763,282			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,264	17,264		17,264		17,264			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			112,788	112,788	(10,277)	102,511		102,511			26
27	Other (specify):*		2,170	849	3,019		3,019		3,019			27
28	**TOTAL General Administration**	320,828	20,908	1,682,293	2,024,029		2,024,029	(298,186)	1,725,843			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,312,677	1,268,050	2,601,675	10,182,402		10,182,402	(365,868)	9,816,534			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethany Terrace Nursing Centre #0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			635,413	635,413		635,413	29,342	664,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			67,821	67,821		67,821		67,821			35
36	Other (specify):*											36
37	**TOTAL Ownership**			703,234	703,234		703,234	29,342	732,576			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,829	1,829		1,829		1,829			41
42	Provider Participation Fee			149,467	149,467		149,467		149,467			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			151,296	151,296		151,296		151,296			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,312,677	1,268,050	3,456,205	11,036,932		11,036,932	(336,526)	10,700,406			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(67,682)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20,400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(880)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,962)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(184,579)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (184,579)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (273,541)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bethany Terrace Nursing Centre

ID# 0015651

Report Period Beginning: 10/1/02

Ending: 9/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Public Relations	$ (44,900)	17	1
2	Public Relations	(647)	20	2
3	Corporate Transfers	(1,917)	21	3
4	Marketing	(44,863)	19	4
5	Special Revenue	(385)	17	5
6	Health Info Management	(495)	17	6
7	Depreciation	29,342	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/02 **Ending:** 9/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(67,682)	0	0	0	0	0	0	0	0	0	0	(67,682)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(67,682)	0	0	0	0	0	0	0	0	0	0	(67,682)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(230,359)	0	0	0	0	0	0	0	0	0	0	(230,359)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,863)	0	0	0	0	0	0	0	0	0	0	(44,863)	19
20	Fees, Subscriptions & Promotions	(647)	0	0	0	0	0	0	0	0	0	0	(647)	20
21	Clerical & General Office Expenses	(22,317)	0	0	0	0	0	0	0	0	0	0	(22,317)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(298,186)	0	0	0	0	0	0	0	0	0	0	(298,186)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(365,868)	0	0	0	0	0	0	0	0	0	0	(365,868)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/02 **Ending:** 9/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,342	0	0	0	0	0	0	0	0	0	0	29,342	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	29,342	0	0	0	0	0	0	0	0	0	0	29,342	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(336,526)	0	0	0	0	0	0	0	0	0	0	(336,526)	45

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Methodist Hospital	Chicago, IL	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Corporate Salary	$ 99,989	Methodist Hospital of Chicago	100.00%	$ 54,994	$ (44,995)	1
2	V		Corporate Benefits	129,706	Methodist Hospital of Chicago	100.00%	54,476	(75,230)	2
3	V		Corporate Pro Fees	40,032	Methodist Hospital of Chicago	100.00%	22,017	(18,015)	3
4	V		Corporate Other	38,975	Methodist Hospital of Chicago	100.00%	21,436	(17,539)	4
5	V		Hospital Administrative	28,800	Methodist Hospital of Chicago	100.00%		(28,800)	5
6	V		Hospital Accounting	87,342	Methodist Hospital of Chicago	100.00%	87,342		6
7	V		Hospital EDP	33,947	Methodist Hospital of Chicago	100.00%	33,947		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 458,791			$ 274,212	$ * (184,579)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Methodist Hospital of Chicago
Street Address: 5025 N Paulina
City / State / Zip Code: Chicago, IL 60640
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Corporate Salary	% to Total Cost	100	Various	$ 399,955	$	25	$ 99,989	1
2		Corporate Benefits	% to Total Cost	100	Various	518,823		25	129,706	2
3		Corporate Pro Fees	% to Total Cost	100	Various	160,127		25	40,032	3
4		Corporate Other	% to Total Cost	100	Various	155,899		25	38,975	4
5		Hospital Administration	% to Total Cost	100	Various	28,800		100	28,800	5
6		Hospital Accounting	% to Total Cost	100	Various	349,369		25	87,342	6
7		Hospital Data Processing	% to Total Cost	100	Various	377,188		9	33,947	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,990,161	$		$ 458,791	25

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Terrace Nursing Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015651

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facilty	183,600	1965	$ 189,809	1
2	Terrace Land Triangle		1996	92,064	2
3	TOTALS	183,600		$ 281,873	3

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	275		1965	1965	$ 1,332,134	$ 4,112	40	$ 33,303	$ 29,191	$ 1,327,962	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Water Main System			1988	92,988	3,720	25	3,720		57,653	10
11	Parking Lot			1994	1,460	121	12	121		1,156	11
12	Parking Lot Improvement			1995	6,525	652	10	652		5,546	12
13	Landscaping			1995	2,800	280	10	280		2,380	13
14	Landscaping			1999	10,191	510	20	510		2,294	14
15	Upper Parking Lot Paving			1999	13,450	897	15	897		4,036	15
16	Paving Stones			1999	5,300	530	10	530		1,855	16
17	Stoning Grading			2000	14,029	1,403	10	1,403		4,910	17
18	Stairs and Concrete Walk			2000	4,475	112	40	112		392	18
19	Sealcoat			2000	2,271	284	8	284		994	19
20	Paving Stones			2000	3,390	424	8	424		1,484	20
21	Remodeling			1973	68,384	2,138	32	2,138		65,179	21
22	Fire Alarm System			1975	18,001	600	30	600		17,100	22
23	Improvements Lane Conversion			1975	42,023	1,400	30	1,400		39,922	23
24	Dietary Improvements			1983	66,649	1,666	20	1,666		66,649	24
25	Dietary Electrical Work			1984	10,348	517	20	517		10,089	25
26	Dietary Remodeling			1984	58,142	2,907	20	2,907		56,688	26
27	Terrace Anderson Lane Remodeling			1984	13,370	669	20	669		13,036	27
28	Kitchen and Employee Dining Room			1985	392,466	19,212	20	19,623	411	363,649	28
29	Electrical Rewiring			1985	59,165	2,896	20	2,958	62	54,820	29
30	Electrical Work			1986	170,088	8,948	19	8,948		156,657	30
31	Dental Suite			1986	4,260	224	19	224		3,923	31
32	Wheelchair Access			1986	16,030	842	19	842		14,763	32
33	Nurses Station			1986	16,532	870	19	870		15,226	33
34	Heating/Cooling Lines			1986	44,252	2,329	19	2,329		40,758	34
35	Dietary Remodeling			1986	166,018	8,738	19	8,738		152,912	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Nurses Station	1986	$ 107,800	$ 5,674	19	$ 5,674	$	$ 99,290	37
38	Dietary Improvements	1987	4,547	252	18	252		4,168	38
39	Improvements	1987	51,547	2,862	18	2,862		47,250	39
40	Rotunda Remodeling	1988	157,446	9,262	17	9,262		143,554	40
41	Soffits	1988	9,558	562	17	562		8,714	41
42	Beauty Shop Remodeling	1988	4,784	282	17	282		4,362	42
43	Wallenius Utility Room	1988	8,916	524	17	524		8,129	43
44	Snack Bar Improvements	1988	18,186	1,070	17	1,070		16,582	44
45	Plumbing	1989	3,399	212	16	212		3,081	45
46	Main Dining Room Interior Design	1989	30,672	1,917	16	1,917		27,797	46
47	Rotunda Renovation	1989	22,188	1,386	16	1,386		20,108	47
48	Utility Rooms	1989	2,495	156	16	156		2,262	48
49	Remodeling	1989	246,688	15,418	16	15,418		223,562	49
50	Bendix Remodeling	1990	2,272	152	15	152		2,045	50
51	Terrace Lobby Remodeling	1992	2,991	230	13	230		2,645	51
52	Storage Shed	1992	2,450	164	15	164		1,878	52
53	Alzheimer Project	1992	1,132,621	87,124	13	87,124		1,001,934	53
54	Lindgren Remodeling	1992	137,974	10,614	13	10,614		122,054	54
55	Wall Covering Protection	1993	4,631	232	10	232		4,631	55
56	Ashbury Remodeling	1993	156,141	13,012	12	13,012		136,622	56
57	Lundgren Remodeling	1993	1,680	84	10	84		1,680	57
58	LOBB/Offices	1993	4,300	358	12	358		3,762	58
59	Physical Therapy/Sensory Room	1993	61,250	5,104	12	5,104		53,593	59
60	Remodeling	1994	153,823	15,377	10	15,377		146,131	60
61	Roof Repairs	1995	2,067	207	10	207		1,758	61
62	Receiving Door	1996	1,327	133	10	133		996	62
63	Outpatient Clinic	1996	5,387	359	15	359		2,693	63
64	Roofing	1996	11,000	1,100	10	1,100		8,251	64
65	Terrace Remodel	1996	1,353,487	90,232	15	90,232		676,743	65
66	Hallway Door	1996	835	83	10	83		626	66
67	Daycare Parking	1997	1,372,256	34,306	40	34,306		222,989	67
68	Architectural Building	1997	2,608	261	10	261		1,696	68
69	Roofing	1997	777	39	20	39		253	69
70	TOTAL (lines 4 thru 69)		$ 7,712,844	$ 365,749		$ 395,413	$ 29,664	$ 5,483,872	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,712,844	$ 365,749		$ 395,413	$ 29,664	$ 5,483,872	1
2	Electrical Lighting	1997	768	38	20	38		248	2
3	Ceiling	1998	4,028	268	15	268		1,475	3
4	Insulation	1999	22,595	1,130	20	1,130		5,085	4
5	Doors	1999	9,679	645	15	645		2,903	5
6	Chapel Renovation	1999	123,276	6,164	20	6,164		27,738	6
7	Fence around generator	2000	2,491	166	15	166		581	7
8	Thermopane Windows	2001	201,057	5,026	40	5,026		11,727	8
9	Remodeling	2001	455,626	22,781	20	22,781		53,156	9
10	Chiller	2002	39,169	2,611	15	2,611		4,134	10
11	Roof Replacement	2002	540,218	54,022	10	54,022		58,524	11
12	Roof Construction	2003	275,652	2,297	10	2,297		2,297	12
13	Plate Glass Replacement	1998	2,825	283	10	283		1,554	13
14	Terrace Remodeling	1998	178,041	8,902	20	8,902		48,961	14
15	Laundry Room Remodeling	2003	49,450	824	20	824		824	15
16	Terrace Remodeling	2000	284,128	7,103	40	7,103		24,861	16
17	Carpeting	2001	3,606	721	5	721		1,442	17
18	Nursing Station Speakers	1994	2,025	203	10	203		1,924	18
19	Communication System	1996	6,993	699	10	699		5,244	19
20	Electrical	1997	1,671	84	20	84		544	20
21	Parker Bathtub	2003	7,818	391	10	391		391	21
22	Doors	2003	2,782	62	15	62		62	22
23	Phone and Data Lines	2003	1,508	38	10	38		38	23
24	Personnel Protection Station	1996	1,029	103	10	103		772	24
25	Door Security System	1994	925	93	10	93		879	25
26	Electronic System/Louder Alarms	1993	800	40	10	40		800	26
27	Cubicle Tracks	1994	8,412	841	10	841		7,991	27
28	Locks	1994	3,643	365	10	365		3,461	28
29	Panic Bar Door	1995	950	95	10	95		808	29
30	Electric Parallel Bars	1994	4,808	481	10	481		4,568	30
31	Lights	1993	516	26	10	26		516	31
32	Appliances	2000	8,957	896	10	896		3,135	32
33	Garbage Disposal	2000	2,348	470	5	470		1,644	33
34	TOTAL (lines 1 thru 33)		$ 9,960,638	$ 483,617		$ 513,281	$ 29,664	$ 5,762,159	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,960,638	$ 483,617		$ 513,281	$ 29,664	$ 5,762,159	1
2	Garbage Disposal	2001	2,483	497	5	497		1,118	2
3	Fire System	1991	1,112	75	15	75		926	3
4	Floor Drains	1993	1,961	98	10	98		1,961	4
5	Grill End Load Racks	1994	526	53	10	53		500	5
6	Heating & A/C unit	1994	17,500	875	20	875		8,313	6
7	Light & Power on Emergency Service	1995	8,030	803	10	803		6,826	7
8	Refridgeration	1997	3,409	341	10	341		2,216	8
9	Generator	1998	695	69	5	69		695	9
10	D 336 Motor	1999	1,979	198	10	198		891	10
11	Emergency Generator	1999	184,029	9,202	20	9,202		41,406	11
12	Vinyl Flooring	1999	819	82	10	82		369	12
13	Fuel Tank Storage Upgrade	1999	9,360	1,170	8	1,170		5,265	13
14	Bi-Fuel Conversion System	1999	18,900	945	20	945		4,253	14
15	Garbage Disposal	1999	1,731	347	5	347		1,558	15
16	Dining Hall Sound System	1999	8,550	855	10	855		3,848	16
17	Electro Magnet Locking System	1999	10,658	1,066	10	1,066		3,731	17
18	Boiler Upgrade	2000	5,217	261	20	261		913	18
19	Software for Call Acct. System	2000	3,214	643	5	643		2,250	19
20	ID Card System	2000	5,831	583	10	583		2,041	20
21	Handicap Drinking Fountain	2001	1,580	158	10	158		421	21
22	Nurse Call System	2001	62,523	6,252	10	6,252		16,672	22
23	Bearing Assembly for Circ. Pump	2001	1,397	140	10	140		373	23
24	Voice Cabling	2001	6,143	614	10	614		1,586	24
25	Light Pole	2001	2,840	284	10	284		734	25
26	Sprinkler System Valve	2001	635	42	15	42		105	26
27	Boiler Retubing	2001	3,541	354	10	354		649	27
28	Boiler Tubes	2002	11,926	596	20	596		1,043	28
29	Alarm Stations	2002	6,888	689	10	689		1,149	29
30	Electrical Pipe on Roof	2003	13,811	270	20	270		270	30
31	Cast Iron Waste	2003	1,560	52	10	52		52	31
32	Signage	2003	1,409	47	10	47		47	32
33	Panic Devices	2003	3,235	80	10	80		80	33
34	TOTAL (lines 1 thru 33)		$ 10,364,130	$ 511,358		$ 541,022	$ 29,664	$ 5,874,420	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,364,130	$ 511,358		$ 541,022	$ 29,664	$ 5,874,420	1
2	Expansion Tanks	2003	4,405	110	10	110		110	2
3	Fire Rated Panic Device	2003	663	11	10	11		11	3
4	Indirect Precooler	1994	8,428	843	10	843		8,007	4
5	Light Fixtures	1994	3,167	316	10	316		3,008	5
6	Water Heater	1994	550	36	15	36		349	6
7	Metal Doors	1993	4,485	224	10	224		4,485	7
8	Concrete Pad for Compactor	1994	2,650	176	15	176		1,679	8
9	Wiring Breaker - Trash Compactor	1994	1,000	100	10	100		950	9
10	Workforce Personel Lift Cap	1995	2,955	296	10	296		2,512	10
11	Boiler	1995	41,966	2,098	20	2,098		17,833	11
12	Labor for Exterior Lighting	1995	4,100	410	10	410		3,485	12
13	Overbed Table	1995	2,623	175	15	175		1,487	13
14	Electronic Ballast Reflectors	1996	1,017	101	10	101		763	14
15	Whirl Pool & Lift Bath Trolley	1996	14,287	952	15	952		7,143	15
16	Booster Heater	1998	2,417	242	5	242		2,417	16
17	Carpeting	1998	4,766	477	5	477		4,766	17
18	Locknetics	1998	2,957	296	5	296		2,957	18
19	MBS Delayed Egress System	1998	1,643	110	15	110		603	19
20	Water Cooler	1998	1,395	93	15	93		511	20
21	Carpeting	1998	7,715	771	5	771		7,715	21
22	Convector Motor	1998	886	89	10	89		488	22
23	Wall Cabinets	1998	2,274	152	15	152		835	23
24	Exit Door Alarm	1993	1,600	107	15	107		1,121	24
25	Tellabs Modem	1998	1,211	121	5	121		1,211	25
26	Phone Cabling	2001	7,180	718	10	718		1,915	26
27	Telephone Equipment	1993	2,898	145	10	145		2,898	27
28	Telephone Equipment	1994	64,908	6,490	10	6,490		1,835	28
29	Telephone Equipment	1995	16,762	1,676	10	1,676		14,248	29
30	Cable Communication Lines	1996	10,940	1,367	8	1,367		10,256	30
31	Exit Door System	1997	4,600	460	10	460		2,990	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,590,578	$ 530,520		$ 560,184	$ 29,664	$ 5,983,008	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,654,509	$ 95,904	$ 95,904	$	various	$ 1,227,506	71
72	Current Year Purchases	116,047	8,667	8,667		various	8,667	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,770,556	$ 104,571	$ 104,571	$		$ 1,236,173	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Activities	1988 Ford Van	1988	$ 35,783	$	$	$		$ 35,783	76
77	Facility Maintenance	1988 Ford Wagon	1988	16,826					16,826	77
78	Yard Maintenance	International Tractor	1970	3,000					3,000	78
79										79
80	TOTALS			$ 55,609	$	$	$		$ 55,609	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,698,616	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 635,091	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 664,755	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,664	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,274,790	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 67,821 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,684	$ 104,721	$	1,684	$ 104,721	1
2	Licensed Speech and Language Development Therapist		hrs		363	27,532		363	27,532	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2658 hrs	89,654	2,369	139,543		5,027	229,197	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 89,654	4,416	$ 271,796	$	7,074	$ 361,450	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bethany Terrace Nursing Centre **#** 0015651 **Report Period Beginning:** 10/1/02 **Ending:** 9/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 2,705,081	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		12,338,677	3
4	Supply Inventory (priced at)		484,621	4
5	Short-Term Investments		12,504,325	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		323,108	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to Third Party		(3,971,038)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 24,384,774	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		70,185	12
13	Land		6,106,028	13
14	Buildings, at Historical Cost		48,333,054	14
15	Leasehold Improvements, at Historical Cost		1,880,228	15
16	Equipment, at Historical Cost		14,608,303	16
17	Accumulated Depreciation (book methods)		(47,550,022)	17
18	Deferred Charges		1,505,632	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		19,512,895	21
22	Other Long-Term Assets (spe **Construction in Progress**		26,413,626	22
23	Other(specify):		478,849	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 71,358,778	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 95,743,552	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,973,982	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		879,554	29
30	Accrued Salaries Payable		3,392,476	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		233,332	33
34	Deferred Compensation		6,250	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Party Payors		1,212,177	36
37	Other Current Liabilities		4,572,036	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 12,269,807	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		40,720,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Estimated Liab. For Malpractice Losses		1,352,939	43
44	Accrued Pension Cost		663,423	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 42,736,362	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 55,006,169	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 40,737,383	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 95,743,552	48

***(See instructions.)**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 43,611,814	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 43,611,814	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	421,078	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Gain/Loss for Period**	(1,442,831)	15
16	Other (describe) **Corporate Income**	(1,852,678)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,874,431)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 40,737,383	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,559,009	1
2	Discounts and Allowances for all Levels	(4,215,542)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,343,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,488	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	67,682	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	880	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	93	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,143	23
	D. Non-Operating Revenue		
24	Contributions	20,400	24
25	Interest and Other Investment Income***	24,000	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,400	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,458,010	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,283,520	31
32	Health Care	5,874,853	32
33	General Administration	2,024,029	33
	B. Capital Expense		
34	Ownership	703,234	34
	C. Ancillary Expense		
35	Special Cost Centers	1,829	35
36	Provider Participation Fee	149,467	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,036,932	40
41	**Income before Income Taxes (line 30 minus line 40)****	421,078	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 421,078	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	2,080	2,080	72,603	34.91	2
3	Registered Nurses	52,217	52,217	1,308,894	25.07	3
4	Licensed Practical Nurses	27,056	27,056	498,793	18.44	4
5	Nurse Aides & Orderlies	226,881	226,881	2,503,050	11.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,600	4,600	121,807	26.48	7
8	Rehab/Therapy Aides	4,384	4,384	51,493	11.75	8
9	Activity Director	4,080	4,080	72,929	17.87	9
10	Activity Assistants	15,212	15,212	172,207	11.32	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	56,223	56,223	540,850	9.62	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,552	6,552	93,449	14.26	17
18	Housekeepers	37,830	37,830	312,878	8.27	18
19	Laundry	5,436	5,436	54,487	10.02	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	32,212	32,212	625,886	19.43	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	474,763	474,763	$ 6,429,326 *	$ 13.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	84	$ 5,109	10, 10a col. 3	50
51	Licensed Practical Nurses	182	7,083	10, 10a col. 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	266	$ 12,192		53

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kenneth Kolich	Administrator		$ 97,148
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,148

B. Administrative - Other

Description	Amount
Corporate Allocation	$ 180,228
TOTAL (agree to Schedule V, line 17, col. 3)	$ 180,228
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Carlin & Associates	Med Records Consulting	$ 5,332
Frost, Ruttenber, & Rothblatt	Billing	3,936
Aging and Dementia Care Ltd	Billing	480
Cassidy, Schade, & Gloor	Legal Fees	30,068
Sonnenchein, Nath, & Rosenthal	Legal Fees	4,685
Carol Gordon	Social Services Consulting	2,267
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 46,768

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,598
Unemployment Compensation Insurance	6,670
FICA Taxes	471,153
Employee Health Insurance	202,245
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	8,116
Other	500
TOTAL (agree to Schedule V, line 22, col.8)	$ 763,282

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,592
Health Care Worker Background Check	738
(Indicate # of checks performed)	
Dues & Subscriptions	13,616
Other	3,204
Less: Public Relations Expense	(647)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,503

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,897
Seminar Expense	6,367
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,264

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/02 Ending: 9/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/02 **Ending:** 9/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $8,906**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,691** Line **10.02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **149,467**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **30,470**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PricewaterhouseCoopers LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.